Enrollment/Change Form
GEO℠ Group

- **Groups with 11-24 employees**
- **All employees must complete Parts 1, 2, 5, and 7**
- **Employees anwering Yes to any question in Part 2 must complete Parts 3 and 4**
- **Note Employees applying for life insurance: $10,000-$100,000 also complete Part 6; $100,001-$250,000 complete entire form including all medical questions**

PART 1			
I would like the following coverage: This application is for:	❑ Single Coverage ❑ Late Enrollment ❑ Beneficiary Change ❑ Name Change	❑ Coverage to also include eligible dependents ❑ Addition of Dependent(s) ❑ Address Change	❑ New Employee ❑ Termination Notice ❑ Change of Status ❑ Removal of Dependent(s)
Participation Organization:		Group I.D. Number:	
Employee Name *(Last, First, Middle)*:			
❑ Male ❑ Female	Occupation:	Annual Salary *(Required if applying for 1x, 2x, or 3x salary)*:	Requested Effective Date *(Day, Mo., Yr.)*:
Resident Street Address:		Resident City:	State:
Postal/Zip Code:	Country:	Telephone:	Email Address:
Identification Number:	Date of Birth *(Day, Mo., Yr.)*:	Height:	Weight:
Date Employed Full-Time *(Day, Mo., Yr.)*:	Hours Worked per Week:	Departure Date from U.S. if applicable *(Day, Mo., Yr.)*:	Country of Destination if applicable:
Length of Stay if applicable:	Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? ❑ Yes ❑ No		
Medicare Claim Number *(If you answered Yes to Medicare question)*:		Social Security Number ***(Required)***:	

DEPENDENTS *(ATTACH AN ADDITIONAL FORM IF MORE THAN THREE CHILDREN)* ❑ I am enrolling dependents ❑ I am removing dependents			
Name *(Last, First, Middle)*	1) Date of Birth *(Day, Mo., Yr.)* 2) Date of Marriage to Spouse *(Day, Mo., Yr.)*	Height (H) Weight (W)	Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?
B) Spouse:	1) 2)	H: W:	Medicare Claim Number (MCN) *(If you answered Yes to above question)*: Social Security Number (SSN) ***(Required)***:
C) Dependent Child #1: ❑ Male ❑ Female	1) 2)	H: W:	MCN: SSN ***(Required)***:
D) Dependent Child #2: ❑ Male ❑ Female	1) 2)	H: W:	MCN: SSN ***(Required)***:
E) Dependent Child #3: ❑ Male ❑ Female	1) 2)	H: W:	MCN: SSN ***(Required)***:
For dependent children age 19 or older, please indicate name and address of college or university ***and the number of enrolled hours:***			
I refuse coverage for: ❑ Myself ❑ Spouse ❑ Children		Reason:	
I have been given the opportunity to participate in the group insurance plan offered though my employer and I have refused to participate in the coverage as indicated above. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective. **(SIGN BELOW ONLY IF REFUSING COVERAGE)**			
Signature:		Date *(Day, Mo., Yr.)*:	

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PART 2

The questions below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 1), and provide complete details of the medical condition at issue in the space provided in Part 4 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve the right to request additional medical information.

1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	❑ Yes ❑ No
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	❑ Yes ❑ No
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Lympadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	❑ Yes ❑ No
4. Have you or any other applicant ever had mental or nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abused or dependency, alcoholism, psychiatric counseling and /or support groups, depression, anxiety, chronic fatigue, or eating disorders?	❑ Yes ❑ No
5. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	❑ Yes ❑ No
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain:	❑ Yes ❑ No
7. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain:	❑ Yes ❑ No
8. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental physical or nervous conditions?	❑ Yes ❑ No

PART 3

Questions 9-27 below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 1), and provide complete details of the medical condition at issue in the space provided in Part 4 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve the right to request additional medical information.

Have you or any family member applying for coverage ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:

9. Heart, cardiac, cardiovascular and /or circulatory, including , but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? Date of most recent blood pressure reading:_____ Most recent blood pressure reading: _____AS/ _____DS Medications (Types / Dosage):_____	❑ Yes ❑ No
10. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	❑ Yes ❑ No
11. Diabetes, hyperglycemia or hypoglycemia? If Yes to diabetes, please complete the following: a) Diabetic Type: I ____ or II____ b) Date diagnosed: _____ c) Controlled by diet only? Yes _____ No _____ d) Medications (Types / Dosage) _____ e) Date of most recent HbA 1c Test _____ f) Results of HbA 1c Test (1-10) _____	❑ Yes ❑ No
12. Asthma or allergies? If yes, please specify which one and complete the following: a) Date diagnosed: _____ b) Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ c) Please list known triggers: _____ d) Medications (Types / Dosage) _____ e) Frequency of attacks: _____	❑ Yes ❑ No

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13. Cancer, tumor cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	❑ Yes ❑ No
14. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	❑ Yes ❑ No
15. Kidney, urinary tract functions, kidney or bladder stones or infections?	❑ Yes ❑ No
16. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	❑ Yes ❑ No
17. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	❑ Yes ❑ No
18. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease, vertebrae, or any other back condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	❑ Yes ❑ No
19. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice diagnosis or treatment?	❑ Yes ❑ No
20. Congenital, genetic or hereditary condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	❑ Yes ❑ No
21. Digestive system, stomach or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	❑ Yes ❑ No
22. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	❑ Yes ❑ No
23. Eyes, ears, nose mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation chronic sinusitis, or TMJ?	❑ Yes ❑ No
24. Any other disease, medical problem, illness, injury or condition of any kind not listed?	❑ Yes ❑ No
25. Do you or any family member applying for coverage currently use or during the past 5 years have you used tobacco in any form?	❑ Yes ❑ No
26. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? If yes, please provide policy number and details:	❑ Yes ❑ No
27. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	❑ Yes ❑ No

PART 4 ADDITIONAL INFORMATION

Question #	Name	Details/Diagnosis of Illness/Accident	Expenses in last 5 years	Date last treated *(Day, Mo., Yr.)*	Full name and number of all attending physicians

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PART 5 ****MUST BE COMPLETED****

Has any person listed on the prior page, including dependents, been insured for medical expenses under any policy or plan during the last 12 months, whether individual or group coverage?	❑ Yes ❑ No

If your response to the above question is yes, the following is required:
1) Name of person(s) **2)** A copy of all applicable Certificates of Creditable Coverage

Note: *Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Any claims submitted without Certificates of Creditable Coverage will be processed with any pre-existing condition exclusion as defined by the Group Medical Insurance Master Policy.*

PART 6 EMPLOYEE LIFE INSURANCE

Underwritten by International Medical Insurance Company℠, Inc. (IMIC℠). Distributed, managed and administered as agent for IMIC by International Medical Group®, Inc. ("IMG®").

❑ 1x Salary	❑ 2x Salary	❑ 3x Salary	❑ Other Amount:

SUBSCRIPTION EMPLOYEE LIFE INSURANCE I hereby apply to the Global Life Insurance Services Group Insurance Trust, Bank of Bermuda, Hamilton, Bermuda, for global Term Life Insurance. I understand and agree that: (i) no coverage will be effective until this Application has been duly accepted in writing by the Company, (ii) no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, (iii) IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I purposefully initiate and take advantage of the privilege of conducting business with the Company in Bermuda, through IMG as its selected agent and administrator, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance shall be deemed issued and made in Hamilton, Bermuda, and sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Hamilton, Bermuda, for which applicant(s) hereby consent(s). I agree to use Bermuda law for all rights and claims arising under this insurance.

Employee Signature:	Date *(Day, Mo. Yr.)*:

BENEFICIARY INFORMATION For each employee applying for life insurance, please indicate:

Primary Beneficiary Name:	Relationship to Employee:	Percent of Death Benefit:
Contingent Beneficiary Name:	Relationship to Employee:	Percent of Death Benefit:
Contingent Beneficiary Name:	Relationship to Employee:	Percent of Death Benefit:

PART 7

SUBSCRIPTION I (we) hereby apply to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for GEO Group as offered by the Company on the date of its receipt hereof. I (we) understand and agree that: (i) no coverage will be effective until this Application has been duly accepted in writing by the Company, (ii) no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, (iii) IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its selected agent and administrator, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance shall be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which applicant(s) hereby consent(s). I (we) agree to use Indiana law for all rights and claims arising under this insurance.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) marketing brochures and certificate wordings are available prior to application upon request, (ii) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or to be performed in any particular state of the United States, and (iv) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided thereunder, and IMG acts solely as agent for the Company and has no direct or independent liability under the Master Policy or any Certificate of insurance.

CERTIFICATION I (we) hereby certify, represent and warrant to IMG and the Company that: (i) I (we) have read the questions contained in this Application or they have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, and/or employment status, to provide such information to IMG and/or the Company.

Employee Signature:	Date *(Day, Mo. Yr.)*:
Spouse Signature:	Date *(Day, Mo. Yr.)*:

BENEFITS CHANGE INFORMATION: EMPLOYER USE ONLY

Effective Date *(Day, Mo. Yr.)*:

Change of Status *(Check one)*:	❑ Return to the U.S. Date of Return *(Day, Mo. Yr.)*:	❑ Return to overseas assignment Date of Return *(Day, Mo. Yr.)*:

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